		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039230

Facility Name: OTTAWA PAVILION

Address: 800 E. CENTER ST. (Number) OTTAWA (City) 61350 (Zip Code)

County: LASALLE

Telephone Number: (847)679-8219 **Fax #** (847)679-7377

IDPA ID Number: 36-3919766001

Date of Initial License for Current Owners: 12/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,554	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,554	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,216	4,399	6,744	22,359	8
9	SNF/PED					9
10	ICF	7,512	1,065	12	8,589	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,728	5,464	6,756	30,948	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.06%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 6,121

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	173,296	18,496	4,514	196,306		196,306		196,306			1
2	Food Purchase		157,234		157,234		157,234	(2,709)	154,525			2
3	Housekeeping	103,058	20,484		123,542		123,542		123,542			3
4	Laundry	39,075	9,245	2,118	50,438		50,438		50,438			4
5	Heat and Other Utilities			115,791	115,791		115,791	699	116,490			5
6	Maintenance	49,779	29,461	9,683	88,923		88,923	6,726	95,649			6
7	Other (specify):*			6,787	6,787		6,787	446	7,233			7
8	**TOTAL General Services**	365,208	234,920	138,893	739,021		739,021	5,162	744,183			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,302,631	65,057	58,451	1,426,139		1,426,139	(1,164)	1,424,975			10
10a	Therapy	182,444	1,241	1,390	185,075		185,075		185,075			10a
11	Activities	80,562	5,592	2,409	88,563		88,563		88,563			11
12	Social Services	37,938		3,799	41,737		41,737		41,737			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,603,575	71,890	72,049	1,747,514		1,747,514	(1,164)	1,746,350			16
	C. General Administration											
17	Administrative	54,267		242,000	296,267		296,267	(174,115)	122,152			17
18	Directors Fees											18
19	Professional Services			34,475	34,475		34,475	(763)	33,712			19
20	Dues, Fees, Subscriptions & Promotions			20,630	20,630		20,630	(13,570)	7,060			20
21	Clerical & General Office Expenses	84,761	20,432	108,579	213,772		213,772	(49,675)	164,097			21
22	Employee Benefits & Payroll Taxes			345,973	345,973		345,973		345,973			22
23	Inservice Training & Education			2,287	2,287		2,287		2,287			23
24	Travel and Seminar							406	406			24
25	Other Admin. Staff Transportation			7,803	7,803		7,803		7,803			25
26	Insurance-Prop.Liab.Malpractice			14,006	14,006		14,006	1,268	15,274			26
27	Other (specify):*			28,795	28,795		28,795	(10,826)	17,969			27
28	**TOTAL General Administration**	139,028	20,432	804,548	964,008		964,008	(247,275)	716,733			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,107,811	327,242	1,015,490	3,450,543		3,450,543	(243,277)	3,207,266			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: OTTAWA PAVILION **#0039230** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,044	
	REPAIRS & MAINTENANCE		470	
			0	4,514
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,118	
			0	2,118
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		47,130	
	ELECTRICITY		50,909	
	WATER		16,029	
	CABLE TV - LOBBY		1,723	
			0	115,791
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,168	
	ELEVATOR MAINTENANCE & REPAIR		5,550	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,965	
	FIRE SERVICE		0	
			0	
			0	
			0	9,683
7	**OTHER**			
	SCAVENGER		6,787	
	SECURITY SERVICE		0	6,787
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	54,187	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,080	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	184	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	58,451
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,390	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,390
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,409	
			0	2,409
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,799	
			0	3,799
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OTTAWA PAVILION **#0039230** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	242,000	242,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	3,612	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	30,863	
			0	34,475
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	13,966	
	EMPLOYEE WANT ADS	XIX F	3,730	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	964	
	LICENSES & PERMITS	XIX F	1,663	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	307	20,630
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		11,712	
	OUTSIDE CLERICAL SERVICES		50,500	
	PENALTIES / OVERDRAFT CHARGES	VI 18	33,609	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,758	
	MESSENGER SERVICE		0	
			0	108,579

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	165,314	
	UNEMPLOYMENT COMPENSATION	XIX D	54,491	
	WORKERS COMPENSATION INSURANCI	XIX D	54,754	
	HOSPITALIZATION INSURANCE	XIX D	64,444	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,970	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	345,973
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,287	2,287
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,803	7,803
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		14,006	14,006
27	**OTHER**			
	BAD DEBTS	VI 24	28,795	
				28,795

GRAND TOTAL COLUMN 3 OTHER 1,015,490

Facility Name & ID Number OTTAWA PAVILION #0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			35,321	35,321		35,321	(2,657)	32,664			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,506	52,506		52,506	(3,662)	48,844			32
33	Real Estate Taxes			50,977	50,977		50,977	2,477	53,454			33
34	Rent-Facility & Grounds			242,752	242,752		242,752	(242,752)				34
35	Rent-Equipment & Vehicles			6,973	6,973		6,973	5,154	12,127			35
36	Other (specify):*											36
37	**TOTAL Ownership**			388,529	388,529		388,529	(241,440)	147,089			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		171,023	16,905	187,928		187,928	(1,664)	186,264			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,332	65,332		65,332		65,332			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		171,023	82,237	253,260		253,260	(1,664)	251,596			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,107,811	498,265	1,486,256	4,092,332		4,092,332	(486,381)	3,605,951			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,973)	30		9
10	Interest and Other Investment Income	(5,662)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,924)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(785)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(33,609)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,168)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,795)	27		24
25	Fund Raising, Advertising and Promotional	(13,966)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (91,882)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(394,499)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (394,499)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (486,381)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OTTAWA PAVILION

ID# 0039230

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,709)	0	0	0	0	0	0	0	0	0	0	(2,709)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	699	0	0	0	0	0	0	0	0	699	5
6	Maintenance	0	0	1,424	5,302	0	0	0	0	0	0	0	6,726	6
7	Other (specify):*	0	0	0	0	446	0	0	0	0	0	0	446	7
8	**TOTAL General Services**	(2,709)	0	2,123	5,302	446	0	0	0	0	0	0	5,162	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(1,164)	0	0	0	0	0	(1,164)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(1,164)	0	0	0	0	0	(1,164)	16
	C. General Administration													
17	Administrative	0	(242,000)	0	67,885	0	0	0	0	0	0	0	(174,115)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,168)	0	1,405	0	0	0	0	0	0	0	0	(763)	19
20	Fees, Subscriptions & Promotions	(13,966)	0	396	0	0	0	0	0	0	0	0	(13,570)	20
21	Clerical & General Office Expenses	(33,609)	(50,500)	29,312	5,122	0	0	0	0	0	0	0	(49,675)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	406	0	0	0	0	0	0	0	0	406	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,268	0	0	0	0	0	0	0	0	1,268	26
27	Other (specify):*	(28,795)	0	5,200	0	12,769	0	0	0	0	0	0	(10,826)	27
28	**TOTAL General Administration**	(78,538)	(292,500)	37,987	73,007	12,769	0	0	0	0	0	0	(247,275)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(81,247)	(292,500)	40,110	78,309	13,215	(1,164)	0	0	0	0	0	(243,277)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION # 0039230 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(4,973)	0	2,316	0	0	0	0	0	0	0	0	(2,657)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,662)	0	2,000	0	0	0	0	0	0	0	0	(3,662)	32
33	Real Estate Taxes	0	0	2,477	0	0	0	0	0	0	0	0	2,477	33
34	Rent-Facility & Grounds	0	(242,752)	0	0	0	0	0	0	0	0	0	(242,752)	34
35	Rent-Equipment & Vehicles	0	0	5,154	0	0	0	0	0	0	0	0	5,154	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,635)	(242,752)	11,947	0	0	0	0	0	0	0	0	(241,440)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(1,664)	0	0	0	0	0	(1,664)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(1,664)	0	0	0	0	0	(1,664)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(91,882)	(535,252)	52,057	78,309	13,215	(2,828)	0	0	0	0	0	(486,381)	45

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 242,000	DYNAMIC HEALTHCARE CONSULTANT		$	$ (242,000)	1
2	V	21	BOOKKEEPING SERVICES	50,500	" "			(50,500)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	242,752	OTTAWA PAVILION BUILDING LLC			(242,752)	7
8	V	30	DEPRECIATION		" "				8
9	V	32	INTEREST						9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 535,252			$	$ * (535,252)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 699	$ 699	15
16	V	6	REPAIR & MAINT.		" " "	100.00%	1,424	1,424	16
17	V	19	PROFESSIONAL FEES		" " "	100.00%	1,405	1,405	17
18	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	396	396	18
19	V	21	CLERICAL & GENERAL		" " "	100.00%	29,312	29,312	19
20	V	24	SEMINARS AND TRAVEL		" " "	100.00%	406	406	20
21	V	26	INSURANCE		" " "	100.00%	1,268	1,268	21
22	V	27	EMP. BEN. - GEN, ADMIN.		" " "	100.00%	5,200	5,200	22
23	V	30	DEPRECIATION		" " "	100.00%	2,316	2,316	23
24	V	32	INTEREST		" " "	100.00%	2,000	2,000	24
25	V	33	REAL ESTATE TAXES		" " "	100.00%	2,477	2,477	25
26	V	35	EQUIPMENT RENTAL		" " "	100.00%	5,154	5,154	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 52,057	$ * 52,057	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 5,302	$ 5,302	15
16	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	12,453	12,453	16
17	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	13,773	13,773	17
18	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%			18
19	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%	2,667	2,667	19
20	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%	7,982	7,982	20
21	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	6,519	6,519	21
22	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	11,152	11,152	22
23	V	17	ADMIN. CMP. - HOWARD ALTER		" " "	100.00%			23
24	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	13,339	13,339	24
25	V	21	CLERICAL. CMP. - S. AARON		" " "	100.00%	5,122	5,122	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 78,309	$ * 78,309	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 446	$ 446	15
16	V	27	EMP.BEN. - M. MAUER		" " "	100.00%	1,010	1,010	16
17	V	27	EMP. BEN. - M. AARON		" " "	100.00%	1,522	1,522	17
18	V	27	EMP. BEN. - F. AARON		" " "	100.00%			18
19	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%	2,823	2,823	19
20	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%	2,374	2,374	20
21	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	614	614	21
22	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	1,559	1,559	22
23	V	27	EMP. BEN. - H. ALTER		" " "	100.00%			23
24	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	1,985	1,985	24
25	V	27	EMP. BEN. - S. AARON		" " "	100.00%	882	882	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 13,215	$ * 13,215	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$	DYNAMIC HEALTHCARE CONSULTANTS		$	$	15
16	V	19	PROFESSIONAL FEES	7,170	" " "		7,170		16
17	V	22	EMPLOYEE BENEFITS		" " "				17
18	V	39	ANCILLARY SERVICES		" " "				18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	6,190	LINCOLN MEDICAL SUPPLIES, INC.		5,026	(1,164)	21
22	V	39	ANCILLARY EXPENSE	8,845	" " "		7,181	(1,664)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 22,205			$ 19,377	$ * (2,828)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MAURY AARON		ADMINISTRATIVE			SCHEDULE ATTACHED		SALARY	$ 13,773	17-7	1
2	MARSHALL MAUER		ADMINISTRATIVE					SALARY	12,453	17-7	2
3	SHARON AARON		CLERICAL					SALARY	5,122	21-7	3
4	DENNIS NEHMER		MAINTENANCE					SALARY	5,302	17-7	4
5	SUSAN KOPLIN HARAMARAS		ADMINISTRATIVE					SALARY	7,982	17-7	5
6	DIANA MAGAFAS		ADMINISTRATIVE					SALARY	6,519	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 51,151		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	427,864	12	$ 9,658	$	30,948	$ 699	1
2	6	REPAIR & MAINT.	" "	427,864	12	19,683		30,948	1,424	2
3	19	PROFESSIONAL FEES	" "	427,864	12	19,431		30,948	1,405	3
4	20	DUES AND SUBSCRIPTION	" "	427,864	12	5,469		30,948	396	4
5	21	CLERICAL & GENERAL	" "	427,864	12	405,253	290,672	30,948	29,312	5
6	24	SEMINARS AND TRAVEL	" "	427,864	12	5,616		30,948	406	6
7	26	INSURANCE	" "	427,864	12	17,537		30,948	1,268	7
8	27	EMP. BEN. - GEN, ADMIN.	" "	427,864	12	71,885		30,948	5,200	8
9	30	DEPRECIATION	" "	427,864	12	32,025		30,948	2,316	9
10	32	INTEREST	" "	427,864	12	27,646		30,948	2,000	10
11	33	REAL ESTATE TAXES	" "	427,864	12	34,248		30,948	2,477	11
12	35	EQUIPMENT RENTAL	" "	427,864	12	71,259		30,948	5,154	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 719,710	$ 290,672		$ 52,057	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 65,436	$ 65,436	3	$ 5,302	1
2	17	ADMIN. CMP. - M. MAUER	" "	40	11	170,000	170,000	3	12,453	2
3	17	ADMIN. CMP. - M. AARON	" "	40	9	170,000	170,000	3	13,773	3
4	17	ADMIN. CMP. - F. AARON	" "	47	6	119,100	119,100			4
5	17	ADMIN. CMP. - S. GOLDSTEIN	" "	45	3	24,000	24,000	5	2,667	5
6	17	ADMIN. CMP. - S. KOPLIN	" "	40	7	72,815	72,815	4	7,982	6
7	17	ADMIN. CMP. - D. MAGAFAS	" "	45	9	80,395	80,395	4	6,519	7
8	17	ADMIN. CMP. - S. LEVY	" "	45	11	152,350	152,350	3	11,152	8
9	17	ADMIN. CMP. - H. ALTER	" "	40	1	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	" "	45	9	164,490	164,490	4	13,339	10
11	21	CLERICAL. - S. AARON	" "	40	11	69,932	69,932	3	5,122	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,100,518	$ 1,100,518		$ 78,309	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 5,508	$	3	$ 446	1
2	27	EMP.BEN. - M. MAUER	" "	40	11	13,783		3	1,010	2
3	27	EMP. BEN. - M. AARON	" "	40	9	18,779		3	1,522	3
4	27	EMP. BEN. - F. AARON	" "	47	6	34,154				4
5	27	EMP. BEN. - S. GOLDSTEIN	" "	45	3	25,404		5	2,823	5
6	27	EMP. BEN. - S. KOPLIN	" "	40	7	21,655		4	2,374	6
7	27	EMP. BEN. - D. MAGAFAS	" "	45	9	7,575		4	614	7
8	27	EMP. BEN. - S. LEVY	" "	45	11	21,295		3	1,559	8
9	27	EMP. BEN. - H. ALTER	" "	40	1	1,244				9
10	27	EMP. BEN. - NON-OWNER	" "	45	9	24,475		4	1,985	10
11	27	EMP. BEN. - S. AARON	" "	40	11	12,038		3	882	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 185,910	$		$ 13,215	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION							2
3	19	PROFESSIONAL FEES	" "						7,170	3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "							5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						5,026	9
10	39	ANCILLARY EXPENSE	" "						7,181	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 19,377	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HAJEK/REICHERT		X	MORTGAGE	$36,043.00	12/01/98	$ 3,800,000	$	12/18	9.7500	$	1
2												2
3	SHAREHOLDERS	X		WORKING CAPITAL				455,500			14,852	3
4	INTERCOMPANY	X		WORKING CAPITAL			350,000	350,000			18,958	4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL				523,402		PRIME+	18,183	6
7			X	INSURANCE				28,773			513	7
8	RELATED PARTY	X									2,000	8
9	TOTAL Facility Related				$36,043.00		$ 4,150,000	$ 1,357,675			$ 54,506	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,150,000	$ 1,357,675			$ 54,506	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$ 52,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 50,977	2
3. Under or (over) accrual (line 2 minus line 1).	$ (1,023)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 52,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 50,977	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	49,910	8
2000	50,378	9
2001	50,521	10
2002	50,607	11
2003	50,977	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OTTAWA PAVILION COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0039230

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-13-111-001	NURSING HOME	$ 50,977.36	$ 50,977.36
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,977.36	$ 50,977.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,128 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1998	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		1998		$	$		$	$	$	4
5											5
6											6
7											7
8					32,086	823	35	917	94	10,390	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1994	13,015	333	39	333		3,476	9
10	WALLPAPER			1995	18,314	470	39	470		4,343	10
11	DRYWALL IN CORRIDOR			1995	17,550	450	39	450		4,181	11
12	HANDRAILS			1995	7,839	201	39	201		1,851	12
13	SECURITY DOOR			1995	1,602	41	39	41		371	13
14	MIXING VALVE & WATER HEATER			1995	756	19	39	19		172	14
15	HANDRAIL & BUMPER			1996	6,895	177	39	177		1,586	15
16	HANDRAIL & BUMPER			1996	721	18	39	18		156	16
17	ALARM			1996	1,146	29	39	29		244	17
18	PANIC DEVICE			1996	1,550	40	39	40		328	18
19	REPLACE RECONNECT SWITCH & STARTER			1996	1,074	28	39	28		227	19
20	DRAPERIES			1996	13,334	342	39	342		2,750	20
21	DRAPERY, CARPETING			1997	12,786	328	39	328		2,366	21
22	PIPING WORK, HEAT/COOL UNITS			1997	4,341	111	39	111		805	22
23	HEAT/COOL UNITS			1998	4,732	131	39	131		855	23
24	OFFICE REMODELING			1998	1,475	38	39	38		249	24
25	SHELVING/COOLER			1998	1,493	28	39	28		191	25
26	BOILER, HEAT/COOL UNIT			1999	10,441	268	39	268		1,577	26
27	ALARM SYSTEM			1999	2,853	73	39	73		435	27
28	WINDOWS			1999	19,785	507	39	507		2,837	28
29	FOLDING STEEL GATE			1999	884	23	39	23		116	29
30	REMODELING DISHWASHER ROOM			1999	5,000	128	39	128		645	30
31	DRAPERIES			1999	6,439	165	39	165		859	31
32	PARKING LOT PAVING			1999	1,834	47	39	47		262	32
33	BASEMENT REMODEL			2000	15,203	553	27.5	553		2,402	33
34	WINDOW REPAIR -- DOOR			2000	3,026	110	27.5	110		477	34
35	FEED PUMP -- HOT WATER VALVE			2000	4,131	150	27.5	150		653	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SPRINKLER SYSTEM REPAIR	2000	$ 1,175	$ 43	27.5	$ 43	$	$ 187	37
38	AIR CONDITIONER	2000	1,273	46	27.5	46		200	38
39	CARPETING -- SHEERS	2000	5,693	508	20	285	(223)	2,391	39
40	BASEMENT REMODEL	2001	20,088	730	27.5	730		2,540	40
41	BIOLER/SPRINKLER REPAIRS	2001	10,031	365	27.5	365		1,268	41
42	BOILER REPAIR/PUMP/COMPRESSOR	2002	11,888	432	27.5	432		1,015	42
43	HEATER	2002	2,938	107	27.5	107		230	43
44	BASEMENT REMODEL	2002	18,705	680	27.5	680		1,677	44
45	BOILER REPAIR/PUMPS/CONDENSING UNIT	2003	9,701	353	27.5	353		515	45
46	SPRINKLER SYSTEM REPAIR	2003	16,320	593	27.5	593		865	46
47	DOOR CAMERAS AND LOCKS	2003	4,591	167	27.5	167		243	47
48	AIR CONDITIONER 5 TON	2003	1,960	71	27.5	71		101	48
49	SERVICE SINK	2003	802	29	27.5	29		42	49
50	WALL REPAIR - WATER DAMAGE	2003	1,370	50	27.5	50		73	50
51	PAINTING	2004	17,082	285	27.5	285		285	51
52	BOILER,CONDENSATE DRUMS & COMPRESSOR	2004	3,277	55	27.5	55		55	52
53	STAINLESS STEEL TOPS FOR TABLES	2004	1,065	17	27.5	17		17	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 338,264	$ 10,162		$ 10,033	$ (129)	$ 56,508	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 199,848	$ 13,593	$ 18,008	$ 4,415	10	$ 109,592	71
72	Current Year Purchases	16,995	9,785	850	(8,935)	10	850	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	20,358	1,029	1,519	490	10	14,935	74
75	TOTALS	$ 237,201	$ 24,407	$ 20,377	$ (4,030)		$ 125,377	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1999 DODGE RAM VAN	2002	$ 13,563	$ 2,604	$ 2,173	$ (431)	5	$ 9,226	76
77	RELATED PARTY			4,072	464	81	(383)		4,072	77
78										78
79										79
80	TOTALS			$ 17,635	$ 3,068	$ 2,254	$ (814)		$ 13,298	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 993,100	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,637	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 32,664	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,973)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 195,183	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 6,973 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number OTTAWA PAVILION

STATE OF ILLINOIS
0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			9,167			9,167	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				155,487		155,487	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES,LAB, RADIOLOGY Other (specify):					7,738	15,536		23,274	13
14	TOTAL			$		$ 16,905	$ 171,023		$ 187,928	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	802,415		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,739		6
7	Other Prepaid Expenses	4,753		7
8	Accounts Receivable (owners or related parties)	187,700		8
9	Other(specify): RE TAX ESCROW	49,862		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,063,469	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	306,178		15
16	Equipment, at Historical Cost	230,406		16
17	Accumulated Depreciation (book methods)	(246,949)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 289,635	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,353,104	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 466,076	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	555,378		29
30	Accrued Salaries Payable	142,553		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,493		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,000		32
33	Accrued Interest Payable	2,643		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,235,143	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	805,500		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 805,500	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,040,643	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (687,539)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,353,104	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (729,740)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (729,740)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	42,201	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 42,201	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (687,539)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,043,649	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,043,649	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	83,298	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 83,298	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,662	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,662	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT EARNED	1,924	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,924	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,134,533	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	739,021	31
32	Health Care	1,747,514	32
33	General Administration	964,008	33
	B. Capital Expense		
34	Ownership	388,529	34
	C. Ancillary Expense		
35	Special Cost Centers	187,928	35
36	Provider Participation Fee	65,332	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,092,332	40
41	**Income before Income Taxes (line 30 minus line 40)****	42,201	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 42,201	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,945	2,171	$ 57,172	$ 26.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,804	7,889	181,272	22.98	3
4	Licensed Practical Nurses	19,684	20,014	359,987	17.99	4
5	Nurse Aides & Orderlies	63,287	65,297	679,390	10.40	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,745	6,069	182,444	30.06	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,961	2,092	23,856	11.40	9
10	Activity Assistants	7,177	7,500	56,706	7.56	10
11	Social Service Workers	3,185	3,555	37,938	10.67	11
12	Dietician					12
13	Food Service Supervisor	2,041	2,088	30,192	14.46	13
14	Head Cook	7,525	7,815	72,776	9.31	14
15	Cook Helpers/Assistants	9,113	9,319	70,328	7.55	15
16	Dishwashers					16
17	Maintenance Workers	4,620	4,683	49,779	10.63	17
18	Housekeepers	13,326	13,847	103,058	7.44	18
19	Laundry	5,146	5,372	39,075	7.27	19
20	Administrator	1,961	2,039	54,267	26.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,059	6,374	84,761	13.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,001	2,127	24,810	11.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,580	168,251	$ 2,107,811 *	$ 12.53	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	170	$ 4,044	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		4,080	10-3	39
40	Physical Therapy Consultant		1,390	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	61	2,409	11-3	44
45	Social Service Consultant	58	3,799	12-3	45
46	Other(specify) PSYCHIATRIC		184	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	289	$ 21,906		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses	1,290	54,187	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	1,290	$ 54,187		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARGIE LYLE	ADMIN		$ 54,267
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 54,267

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 242,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 242,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK, BOKOR	ACCOUNTING	$ 11,383
DENNIS B. PORICK	LEGAL	390
SACHNOFF, WEAVER	LEGAL	3,020
APLINGTON, KAUFMAN	LEGAL	1,753
APLINGTON, KAUFMAN	COLLECTION FEES	25
PERSONNEL PLANNERS	UC CONSULTANT	1,180
ECONOCARE	PURCHASING CONSLT	2,142
HEALTH DATA SYS	DATA PROCESSING	3,612
DYNAMIC REHAB CONSLT	CONSULTANT	7,170
ASSURANCE AGENCY	INSURANCE	800
FROST RUTTENBERG	ACCOUNTING	3,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 34,475

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 54,754
Unemployment Compensation Insurance		54,491
FICA Taxes		165,314
Employee Health Insurance		64,444
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		6,970
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,730
Health Care Worker Background Check	307
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	13,966
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	1,663
DUES & SUBSCRIPTIONS	964
MGMT CO ALLOCATION	396
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(13,966)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,060

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
MGMT CO ALLOCATION	406
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 406

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$ 0	$	$	$	$	$

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,676** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,332**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees